MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

September 12, 2002

MedPAC's framework for assessing payment adequacy and updating payments

ISSUE: Last year, we implemented a revised approach for considering payment updates. How can this approach be refined for application this year? In particular, how should we consider current law? How should we address other policy objectives? What is involved in considering the impact of technology passthrough payments?

KEY POINTS: Our approach for updating payments consists of two sequential processes:

- determining whether current payments are too high or too low, and
- determining how much efficient providers' costs will change in the next payment year.

The update recommendation is derived by adding the percentage changes needed for these two factors. Determining whether current payments are too high or too low requires three steps:

- estimating current Medicare payments and costs,
- assessing the adequacy of current payments, and
- adjusting payments, through the update or a distributional change.

In determining the increase in efficient providers' costs, we will focus on the effects of input price inflation (as measured by the appropriate CMS market basket). But will also consider whether the impact of technological advancement will be larger or smaller than expected productivity growth.

At a minimum, considering current law means that we should be aware of—and state in our report—how spending under our recommendation would compare to that under current law. It could also mean asking explicitly whether there is sufficient reason to change the law.

Generally, considering policy objectives beyond matching payments to the costs of efficient providers should be confined to policies designed to affect the distribution of payments—like the indirect medical education (IME) and disproportionate share (DSH) adjustments. This means that decisions regarding overall payment adequacy should not consider other payers's policies, and that IME and DSH payments must be included in the estimate of total payments we use to assess payment adequacy.

The passthrough payments made for specific new technologies in the hospital inpatient and outpatient payment systems should be factored into the second part of our update framework—adjusting for the increase in efficient providers's costs in the coming year. However, the impact of these passthrough payments will depend on whether they are implemented budget neutrally.

ACTION: The Commission will have an opportunity to comment on our approach for assessing payment adequacy and updating payments before we start the process of developing our recommendations for next year's March report. At the next Commission meeting, we will address how to ensure that we take Congressional budget implications into account in making our recommendations.

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September 12, 2002

Trends in Medicare spending

ISSUES: What are the trends in Medicare expenditures in recent years? How do Medicare trends compare to overall national health expenditures? What issues need to be addressed in assessing payment adequacy? What are the budgetary implications of MedPAC recommendations and what data are needed to address those implications?

KEY POINTS:

The information presented in this paper is our first step in providing background data for MedPAC's assessment of payment adequacy. Its purposes are to set the context for future Commission discussions of payment adequacy, and to begin considering the budgetary implications of MedPAC recommendations. At future meetings, staff will present data on national health expenditures, private payers' payments, federal budget trends, and related issues.

Key findings to date are:

- The inpatient hospital sector accounted for the largest share of Medicare fee-for-service spending in 2001 (43 percent), followed by physician (23 percent), outpatient hospital (8 percent), and skilled nursing facility services (7 percent).
- The distribution of Medicare dollars is roughly the same as in 1996, with the notable exception of home health services, which have fallen from 8.5 percent of total fee-for-service spending to 4.4 percent, primarily as a result of payment changes made by the Balanced Budget Act of 1997 (BBA).
- Total fee-for-service spending increased from $207 billion in 1996 to $240 billion in 2001 (an average annual increase of 3 percent). Spending declined in 1998 and 1999, mainly due to BBA-mandated payment reductions and increased fraud and abuse scrutiny.
- Spending increased by 12 percent in 2001, primarily due to payment increases in the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

ACTION:

Staff would like Commissioners to comment on the data presented here and to suggest analyses they would like to see in the future.

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